MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Metroplex Diagnostics 200 Wynnewood Village Dallas, TX 75224	MDR Tracking No.: M4-04-3555-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 54 Texas Mutual Insurance Company	Date of Injury: Employer's Name: Allied All Electric Insurance Carrier's No.: 99C0000329744

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2/19/03	2/19/03	95900- 26 x 4	76.80	76.80
		95904- 26 x 6	115.20	115.20
		95935- 26 x 4	63.60	15.90
		95900- 27 x 4	89.60	89.60
		95904- 27 x 6	134.40	134.40
		95935- 27 x 4	0	-37.10
Total Amount Due				394.80

PART III: REQUESTOR'S POSITION SUMMARY

Since the compensable injury affected both the left and right side of the body, both sides of the NCV are reimbursable. Both technical and professional components are in dispute.

PART IV: RESPONDENT'S POSITION SUMMARY

It is the carrier's position that it is not efficient utilization of healthcare to perform testing on an unaffected extremity per TWCC 1996 MFG Medicine Ground Rule IV, B, 2. (F – Reduced or denied in accordance with the appropriate fee guideline ground rule and/or maximum allowable reimbursement (MAR))

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Medicine Ground Rules IV.B.2.b, pertaining to Reflex Studies, "F" wave studies are reimbursed per extremity only if the compensable injury affected both extremities. If the contra-lateral extremity were tested to compare the affected and unaffected side, the comparison study would be considered to be part of the overall study. The documentation reports that the patient complained of neck pain radiating down the right arm and hand. The comparison study to the left arm is included with the "F" wave study to the right arm. Therefore only one "F" wave study is reimbursable in this dispute.

According to the EOBs and Table of Disputed Services the technical component (modifier –27) for 95935 was overpaid by 1 unit x $53 x 70% = $37.10. Proper reimbursement for 95935-26 in this dispute is the right extremity at $53.00 x 30% = $15.90.

In accordance with the Act §413.016 and Commission Rule §134.800(f), the Commission will order an offset of the overpayment towards the total amount of additional reimbursement recommended in this Findings and Decision as indicated in the above table.

The Ground Rule for Reflex Studies regarding the unaffected extremity is not applicable to the other NCV studies.

The CPT descriptor for codes 95900 and 95904 allow reimbursement per nerve tested. As the documentation supports that both upper extremities were tested and right and left modifiers were used with each professional and technical component billed, the requestor is entitled to additional reimbursement as indicated in the above table.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$394.80**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Patti Lanfranco Typed Name	June 30, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P. O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____